MIR-1
Motion for Interlocutory Relief
May 29, 1997 Edition

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS CLAIMS
CLAIM NO. _____
BEFORE _____

_____
(EMPLOYEE) **PLAINTIFF**

VS. **MOTION FOR INTERLOCUTORY RELIEF**

_____
(EMPLOYER) **DEFENDANTS**

_____
(**OTHER DEFENDANTS)**

_____
(**SPECIAL FUND)**

****

The undersigned moves for the following interlocutory relief **(check all that apply)**:

? Payment of medical expenses while the claim is pending.
? Payment of temporary total disability income benefits while the claim is
? Vocational rehabilitation evaluation and services.

In support of this motion, the following documents are attached **(check all that apply)**:

____1. Affidavit establishing that the requesting party is eligible for benefits under KRS Chapter 342, and that irreparable injury, loss or damage will result if interlocutory relief of medical expenses is not granted.

____2. Affidavit establishing that the requesting party is eligible for income benefits under KRS Chapter 342, and that irreparable injury, loss or damage will result if interlocutory relief of temporary total income benefits is not granted.

_____3. If rehabilitation service is requested, an affidavit showing immediate provision of rehabilitation services will substantially increase the probability that the employee will return to work.

____4. Medical report of Dr._____.
(DOCTOR'S NAME)
supporting entitlement to benefits.

Based upon the foregoing, _____ moves for the
(EMPLOYEE)
appropriate relief.

Respectfully submitted,

_____
(Employee's Signature)

_____
(Employee's Street Address)

_____
(Employee's City/State/Zip Code)

The undersigned, being duly sworn, states the foregoing statements in this motion are true and accurate to the best of my knowledge and belief.

_____
(**Employee's Signature)**

Subscribed and sworn to before me this _____ day of _____ 20____.

_____

NOTARY PUBLIC

My Commission expires: _____ County:_____

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact commits a fraudulent insurance act, which is a crime.

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Office of Workers Claims, Prevention Park, 657 Chamberlin Avenue Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employer or Insurance Carrier_____
if applicable: **(Attorney Name or Law Firm)**

_____

(**Attorney Address or Law Firm Street Address)**

_____

(Attorney Address, City/State/Zip)

Employer or Insurance Carrier:

_____

(Company Name or Employer Name)

_____

(Company or Employer Street Address)

_____

(Company or Employer City/State/Zip)

Other Parties, if applicable:

_____

(Name of Party)

_____

(Party Street Address)

_____

(Party City/State/Zip)

Special Fund, if applicable:

_____

(Special Fund)

_____

(Special Fund Street Address)

_____

(Special Fund City/State/Zip)

This _____ day of _____, 20____.

_____

(Employees Signature)